Delaware Center for Health Innovation

Cross-Committee meeting

Gallery Walk Committee Updates
November 10, 2015

Contents

Overview: Clinical Committee

1 Common Scorecard

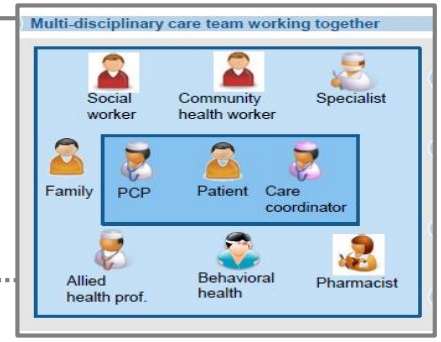
- **What it is:** Quality, cost, experience measures across all payers, eventual goal is for a single scorecard for all payers
- **Where we are today:** Version 2.0 measure approved by the Board
- **Next steps:** Prepare for state-wide roll-out of version 2.0 in mid-2016

2 Practice Transformation

- **What it is:** Common approach to help providers adopt changes in clinical, operational workflows and build the capabilities to coordinate care
- **Where we are today:** Consensus paper on capabilities, milestones, and support model published, RFP released by HCC for expert vendors, provider outreach and enrollment beginning mid-November
- **Next steps:** Support provider outreach and enrollment for practice transformation

3 Care Coordination

- **What it is:** Supporting practices to work with their patients to navigate the health system
- **Where we are today:** Developing support model in light of changing environment and emerging sources of support, drafted consensus paper
- **Next steps:** Get to consensus by end of year



4 Behavioral Health Integration

- **What it is:** Strategy to integrate primary care and behavioral health
- **Where we are today:** Identified current barriers and diversity of best practices across country and state, convened working group of experts to inform strategy for BHI
- **Next steps:** Develop strategy and implementation plan by end of year

Common Scorecard Version 2.0

Category		Measures	Measure type	Data source	Type
Quality of care	1	Diabetes: HbA1c control	HEDIS (CDC)[1]	CPT-II/ Lab	Reporting
	2	Diabetes: Medical attention for nephropathy	HEDIS (CDC)[2]	Claims	Accountable
	3	Medication adherence in diabetes	NQF #541[3]	Claims	Accountable
	4	Medication adherence in high blood pressure: RASA	NQF #541	Claims	Accountable
	5	Adherence to statin therapy for individuals with cardiovascular disease	HEDIS (SPC)	Claims	Accountable
	6	Medication management for people with asthma	HEDIS (MMA)	Claims	Accountable
	7	High risk medications in the elderly	HEDIS (DAE)	Claims	Accountable
	8	Colorectal cancer screening	HEDIS (COL)	Claims	Accountable
	9	Cervical cancer screening	HEDIS (CCS)	Claims	Accountable
	10	Breast cancer screening	HEDIS (BCS)	Claims	Accountable
	11	BMI assessment	HEDIS (ABA)	Claims	Reporting
	12	Screening and follow-up for clinical depression	NQF #418	G-code	Reporting
	13	Avoidance of antibiotic treatment in adults with acute bronchitis	HEDIS (AAB)	Claims	Accountable
	14	Appropriate treatment for children with URI	HEDIS (URI)	Claims	Accountable
	15	Childhood immunization status	HEDIS (CIS)[4]	Claims	Accountable
	16	Developmental screening in the first three years of life	NQF #1448	Claims	Reporting
	17	Fluoride varnish application for pediatric patients	Custom	Claims	Reporting
	18	HPV vaccination for female adolescents	HEDIS (HPV)	Claims	Accountable
	19	Adolescent well-care visits	HEDIS (AWC)	Claims	Accountable
	20	Well child care: 0-15 months	HEDIS (W15)	Claims	Accountable
	21	Well child care: 3-6 years	HEDIS (W34)	Claims	Accountable
Utilization	22	Follow-up within 7 days after hospital discharge	Custom[5]	Claims	Reporting
	23	Plan all-cause readmissions	HEDIS (PCR)	Claims	Accountable
	24	Inpatient utilization	HEDIS (IHU)	Claims	Accountable
	25	Emergency department utilization	HEDIS (EDU)	Claims	Accountable
Total cost of care	26	Total cost of care per patient	Payer defined	Claims	Accountable

1 One component of the Comprehensive Diabetic Care specification; modified HEDIS definition: HbA1c < 9%
2 One component of the Comprehensive Diabetic Care specification
3 Proportion of Days Covered (PDC) specification for: diabetes, renin angiotensin system antagonists
4 Combination 10 is used for this measure
5 Conditions included in this measure: CHF, COPD, pneumonia, and ischemic vascular disease

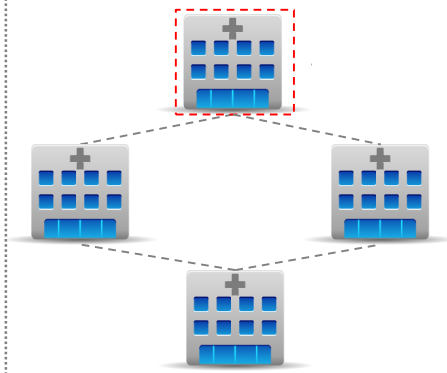
Practice archetypes with varying access to care coordination support

Current care coordination support by practice type

Independent practices

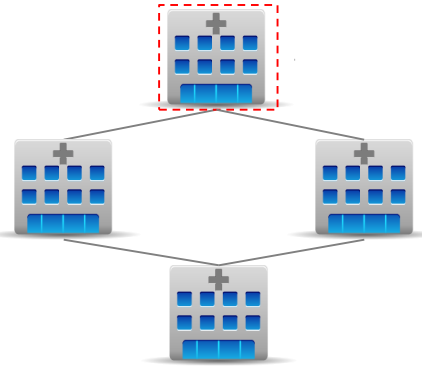
- Given smaller panel sizes, care coordination payments may not be sufficient for practices to effectively source care coordination re-sources/support

Practices affiliated with at least one ACO



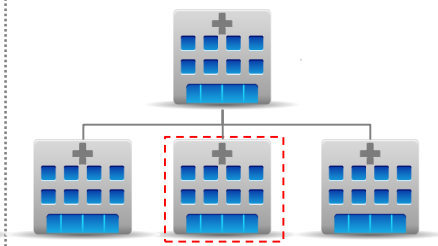
- May receive some technology and/or coaching support for a segment of their panel (e.g., Health coaches)

Practices affiliated with a CIN



- May not have an existing risk arrangement
- May receive support in the form of data or analytics

Practices employed with a health system



- May receive some technology and/or coaching support (e.g., Health coaches)

Your input: Options for care coordination support

PRELIMINARY

Instructions:

- Which potential resource would be most useful for practices to adopt care coordination
- Place **1 dot** on your preferred option
- Use post-it notes to identify any other options not on this list or existing resources that would be useful for the community

Resource	Description	Usefulness
Showcase of successful care coordination	▪ A showcase of successful early adopters to highlight the value and feasibility of care coordination and options for care coordination support.	
Care coordination services directory	▪ a) A directory of organizations (e.g., vendors, ACOs) offering a wide range of care coordination technology and/or services to primary care practice ▪ b) Solicitation of outside vendors to serve the Delaware market.	
Connection service	▪ A service that would facilitate connections between providers who are not already receiving services through existing sources with other providers to share resources/support	
Healthy Neighborhoods to facilitate shared services for PCPs	▪ Practices will use care coordination payments to engage Healthy Neighborhood to source integrated teams that would provide care coordination	

Contents

Overview: Healthy Neighborhoods

1 Healthy Neighborhoods priorities

- **What it is:** Common priority health needs across Delaware – each Healthy Neighborhood can choose one or more as their initial focus
- **Where we are today:** Defined four priority areas based on Delaware needs and potential impact
- **Next steps:** Work with Healthy Neighborhoods in 2016 to select their initial priority

2 Operating model design

- **What it is:** Blueprint for how Healthy Neighborhoods will be formed and how organizations will work together to address statewide health needs in their communities
- **Where we are today:** Board approved consensus paper on Operating model
- **Next steps:** Healthy Neighborhood staff to begin working with Communities to implement operating model in 2016

3 Initial neighborhoods

- **What it is:** Refining Healthy Neighborhoods approach with initial neighborhoods
- **Where we are today:** Identifying what should be tested and location of the initial neighborhoods
- **Next steps:** Finalize approach, identify initial neighborhoods

4 Rollout plan for Healthy Neighborhoods

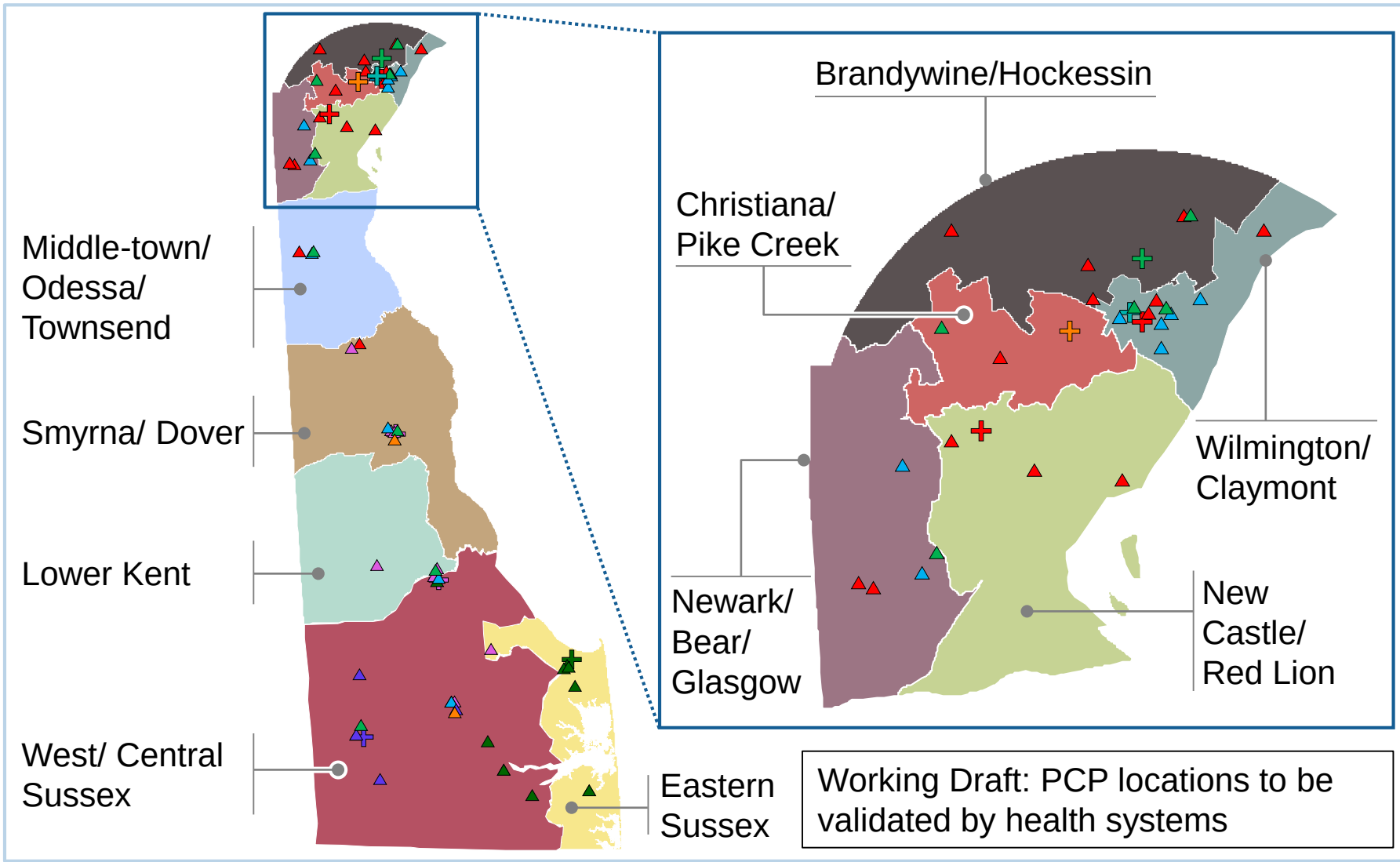
- **What it is:** Define approach for rolling out Healthy Neighborhoods across Delaware
- **Where we are today:** Review initial draft of rollout approach
- **Next steps:** Finalize approach and work to identify initial neighborhoods

Healthy Neighborhoods in Delaware

Hospital
PCP

Affiliation

Beebe | Bayhealth | FQHCs | Veterans Affairs | CCHS | St Francis | Nanticoke | Nemours



SOURCE: Health System and FQHC websites, Esri Geographical Information Services (ArcGIS)

Your input: Healthy Neighborhood rollout

Question: What would be the most appealing reason for your community to participate in the Healthy Neighborhood program?

Instructions: Place **1 dot** on your preferred option, use **post-it notes** to identify any other options not on this list or existing resources that would be useful for the community

Possible options	Your feedback
▪ Ability to align with care delivery innovation (e.g., care coordination, practice transformation)	
▪ Potential to get to sustainable funding	
▪ Opportunity to have everyone at the table	
▪ Dedicated staff and technical assistance	
▪ Coordination of resources (e.g., from state agencies)	
▪ Other	

Contents

Overview: Workforce and Education

1 Credentialing

- **What it is:** Streamline credentialing process
- **Where we are today:** Consensus paper drafted and ready for Committee review
- **Next steps**: Gather feedback and recommendations from Committee members, finalize consensus paper

2 Learning/Re-Learning Curriculum and Consortium development

- **What it is:** Develop curriculum for primary care workforce; build health professionals consortium to expand technical assistance resources throughout the state
- **Where we are today:** Consensus paper on curriculum approved by DCHI board
- **Next steps:** HCC to release RFP(s) for work to begin in Q1 2016

3 Workforce capacity planning

- **What it is:** Identification of future workforce needs to align with anticipated population changes.
- **Where we are today:** Reviewed current data and its limitations, as well as future options. Developed Consensus paper outline
- **Next steps**: Drafting consensus paper

Snapshot of Community Health Workers in Delaware

Models[1]	Description	Examples of CHW programs
Member of care delivery team	▪ CHWs deliver services (e.g., blood pressure measurement, medication counseling) as part of a multi-disciplinary team	▪ **CCHS**: BP Ambassadors
Care coordinator / manager	▪ CHWs help individuals with complex needs navigate health and social services systems (e.g., making appointments, providing transportation)	▪ **CCHS**: Health Ambassadors, MarketPlace Guides ▪ **Nemours**: Pediatric Asthma Pilot
Outreach and enrollment agent	▪ CHWs conduct in-depth home visits, which can include health education, home assessments, and enrollment in appropriate services	▪ **CCHS**: Med Home Without Walls, Independence At Home, Health Ambassadors
Promotora de salud / lay health worker	▪ CHWs are members of target population and serve as bridge (e.g., as advocate, educator, translator) to healthcare delivery system	▪ **CCHS**: Cancer Promotoras ▪ **La Red**: Promotoras ▪ **Westside**: Promotoras
Community organizer and capacity builder	▪ CHWs gather support to implement new programs and promote multi-stakeholder integration (e.g., community groups, providers, State agencies)	▪ N/A
Health educator	▪ CHWs educate target populations on healthy lifestyles and prevention, sometimes providing screening	▪ **CCHS**: Cardiovascular Inflammation Reduction Trial, Camp FRESH, Adolescent Pregnancy Prevention

Level of integration with healthcare system

Delaware has an estimated 190 CHW in 2014 . The Workforce and Education Committee is working with Healthy Neighborhoods to further define the role of Community Health Workers in our delivery system.

1 Not mutually exclusive

SOURCES: Community Health Workers Evidence-Based Models Toolbox (Health Resources and Services Administration); 2014 Bureau of Labor Statistics; Internet Research;

Your feedback: role of DE Community Health Workers

Instructions: What roles would you like to see Community Health Workers play in enhancing population health management and addressing the social determinants of health care? Please place post-its with your ideas below.

Contents

Overview: Patient and Consumer Advisory

1 Messaging and awareness

- **What it is:** Promoting outreach and education to Delawareans about how Delaware's health transformation supports and empowers patients and consumers
- **Where we are today:** Gathered feedback on the approach for patient experience and DCHI engagement strategy, including use of videos and on-line tools
- **Next steps:** Initiate broader patient outreach and communications effort on the goals of DCHI

2 Consumer input to design choices

- **What it is:** Providing consumer perspective input to other committee initiatives
- **Where we are today:** Advocated for improved health literacy in Committees and Board, updated patient/consumer glossary and DCHI website, provided input on consumer needs for the Health IT roadmap
- **Next steps:** Continue to refine patient engagement tools developed by DCHI

Overview: health IT patient and consumer engagement

Health literacy	▪ Basic understanding of healthcare concepts and terms, supported by graphical and video-based explanations ▪ Directory of DE health services and providers, including primary care, acute care and specialists
Consumer transparency for healthcare cost and quality	▪ Publically-available information about healthcare costs and quality, such as: – Information on out-of-pocket costs for tests and procedures – Information on outcomes, volume, safety, patient experience for individual providers and for hospitals
Telehealth	▪ Patient access to care through real-time, two-way telecommunications or electronic communications, used to: – Supplement existing in-person care through more effective and accessible physician interactions – Enable access to specialty care for patients in remote locations
Patient access to their health information	▪ Patient access to health information such as lab results, imaging, and care notes through a web and/or mobile-based interface

Your input: health IT patient and consumer

Instructions:

- Please place one dot next to the **patient and consumer engagement topic you feel is most important for the health IT roadmap**
- If you have **comments in support of your choice, or if there are additional HIT items** you would like to suggest, please write them on a post-it note

	Which topic is the most important for DE? (1 dot)	**Reason for choice / other comments** Post its
Health literacy		
Consumer transparency for healthcare cost and quality		
Telehealth		
Patient access to their health information (e.g., patient portal)		
Other (Please write suggestions on post-its)		

Contents

Potential sources of value for DE claims database

	Description	Users	Examples
Population health management (PHM) applications	▪ Provider ability to analyze cost and quality for population as a whole and respond through clinical pathways / initiatives	▪ Providers	▪ Risk stratification of top 5% expensive patients at risk for heart attack ▪ Outreach to patients overdue for colonoscopy
Baselining and monitoring in value-based payment (VBP)	▪ Provider calculation of potential opportunity for VBP agreements and monitoring cost/quality once agreements begin	▪ Providers	▪ Provider evaluates past 2 years of treatment for a population to determine desirable baseline for VBP agreements
Quality and cost transparency	▪ Understanding of clinical quality (e.g., surgical outcomes) and costs (e.g., out-of-pocket for MRI, total cost to insurer for MRI)	▪ Consumers ▪ Employers ▪ Providers at the point of care	▪ Public-facing website providing information on health costs and quality
Public health planning	▪ Analysis of preventive care, outcomes, cost of care/treatment	▪ Governments ▪ Academic researchers	▪ Analysis of where preventable healthcare events are taking place and causes
Healthcare transformation research	▪ Statewide monitoring of innovation goals (e.g., care coordination, movement to value-based payment)	▪ Government ▪ Providers ▪ Payers	▪ Tracking of percentage of Delawareans and encounters covered by value-based payment agreements

Your input: Sources of value for DE claims database

Instructions:

- Please place one dot next to the **source of value from a statewide claims database that you think is most important for DE healthcare transformation**
- If there are **other examples of value** derived from claims-based information, please write on a post it next to the appropriate category

	Which of these is most important to DE? (1 dot)	**What are other examples of value for this category?** (Post-it note)
Population health management (PHM) applications		
Baselining and monitoring in value-based payment (VBP)		
Quality and cost transparency		
Public health planning		
Healthcare transformation research		

Overview: Continuity of Care Document (CCD)

Overview

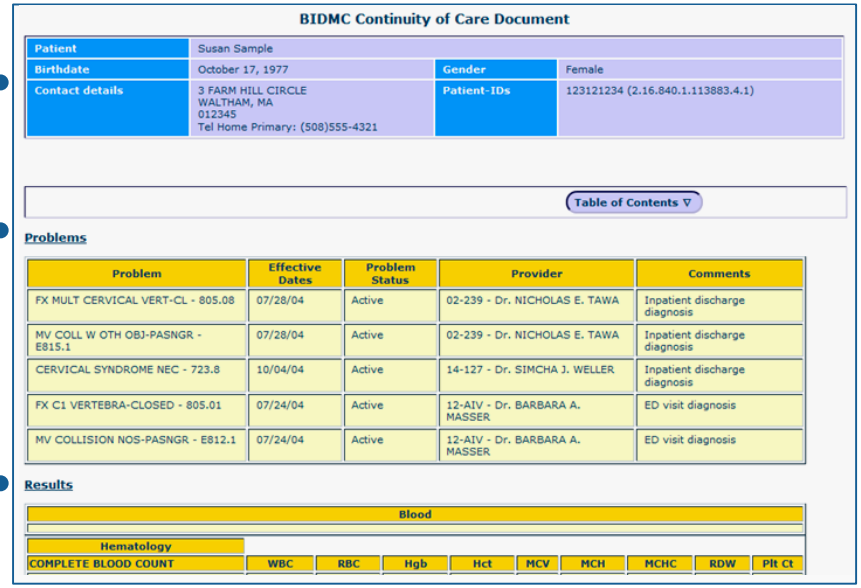
- **The continuity of care document (CCD) is one of the document templates defined by HL-7's CDA (clinical document architecture):** CCD is the encoding, structure, and semantics of a patient summary clinical document for exchange
- For Stage 1 of Meaningful Use, a CCD must include allergies, medication, problems, laboratory results, and patient header information
- For Stage 2 of Meaningful Use, a CCD must include, patient name, sex, date of birth, race, ethnicity, preferred language, smoking status, problems, medications, medication allergies, laboratory tests, laboratory values/results, vital signs, care plan fields including goals and instructions, procedures and care team members (encounter diagnoses, immunizations, referral reason, and discharge instructions may be required based on context)

Example

Patient header

Problems

Lab results



BIDMC Continuity of Care Document

Patient	Susan Sample		
Birthdate	October 17, 1977	Gender	Female
Contact details	3 FARM HILL CIRCLE WALTHAM, MA 012345 Tel Home Primary: (508)555-4321	Patient-IDs	123121234 (2.16.840.1.113883.4.1)

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Problems

Problem	Effective Dates	Problem Status	Provider	Comments
FX MULT CERVICAL VERT-CL - 805.08	07/28/04	Active	02-239 - Dr. NICHOLAS E. TAWA	Inpatient discharge diagnosis
MV COLL W OTH OBJ-PASNGR - E815.1	07/28/04	Active	02-239 - Dr. NICHOLAS E. TAWA	Inpatient discharge diagnosis
CERVICAL SYNDROME NEC - 723.8	10/04/04	Active	14-127 - Dr. SIMCHA J. WELLER	Inpatient discharge diagnosis
FX C1 VERTEBRA-CLOSED - 805.01	07/24/04	Active	12-AIV - Dr. BARBARA A. MASSER	ED visit diagnosis
MV COLLISION NOS-PASNGR - E812.1	07/24/04	Active	12-AIV - Dr. BARBARA A. MASSER	ED visit diagnosis

Results

Blood								
Hematology								
COMPLETE BLOOD COUNT	WBC	RBC	Hgb	Hct	MCV	MCH	MCHC	RDW	Plt Ct

Your input: Sources of value from aggregation of CCDs and limitations

Instructions:

- Please provide examples of **how the aggregation of CCDs could improve healthcare for Delawareans** (e.g., ability to see the results of point of care lab tests, or ambulatory procedures, for the patient and for providers in other sites of care)
- Please provide examples of potential **limitations to the usefulness or feasibility of aggregated CCDs** (e.g., delivery of new patient data must be integrated into provider's existing workflow in order to be viewed)

How can the aggregation of CCDs be used to improve healthcare for Delawareans? (Post-it note)

What may be limitations to usefulness or feasibility of CCDs? (Post-it note)

Contents

Overview: Payment Model Monitoring

1 Identifying and designing common elements of value-based payment models

- **What it is:** Providing a perspective on the design elements of value-based payment (VBP) models (e.g., total cost of care, pay-for-value)
- **Where we are today:** DCHI has discussed several components of VBP model design and identified a few key areas for alignment
- **Next steps:** DCHI will review payer VBP models as details become available and consider alignment of the design elements

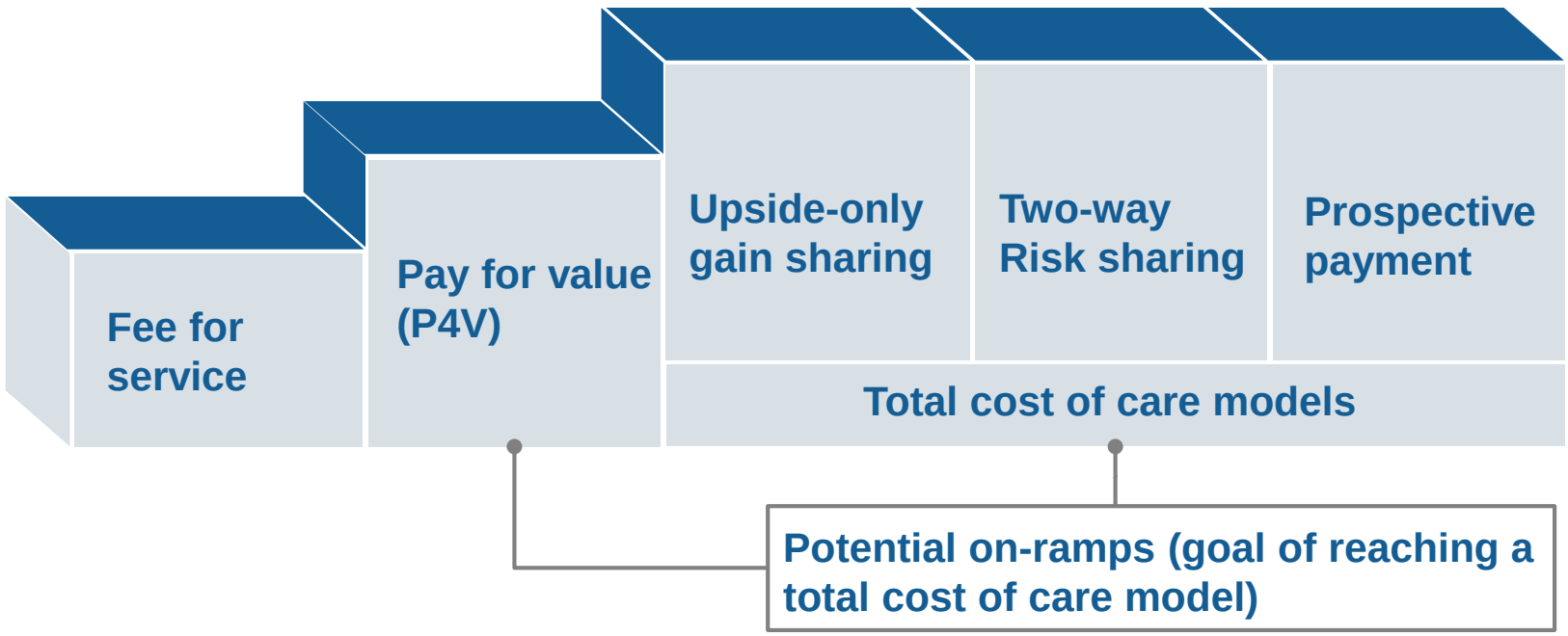
2 Monitoring availability and enrollment in new payment models

- **What it is:** Reviewing information from payers to monitor the availability of VBP models to PCPs and the level of adoption in Delaware
- **Where we are today:** DCHI is actively engaged in ongoing discussions with payers to learn more about new value-based payment models
- **Next steps:** Determine how to support around design elements and producing a white paper

3 Linking payment models to the Common Scorecard

- **What it is:** Working with payers to tie payment incentives within VBP models to performance on measures in the Common Scorecard
- **Where we are today:** DCHI has discussed with payers the goal of having 75% of measures tied to payment drawn from the Scorecard and worked for greater alignment in version 2.0
- **Next steps:** State-wide roll out of version 2.0 Common Scorecard data in the 2nd quarter 2016 with incentives aligned with the Scorecard starting by mid-2016 to early 2017.

Payment model design



Goals for implementation of new payment models

- **Availability:** By 2016, all payers should offer both TCC and P4V for primary care
- **Adoption:** By 2018, adoption of >80% (of PCPs, population, healthcare spending)

Value-based payment metrics: progress towards our goals

Broadly available
Limited or narrow

Goal for availability: "By 2016, all payers should offer both TCC and P4V for primary care"

Goal for adoption: "By 2018, >80% of population and healthcare spending under value-based payment"

Medicare

TCC

- Three tracks of Medicare Shared Savings Program broadly available

P4V

- Care coordination payments available on fee-for-service basis
- Incremental bonuses for quality

40-50% of pop'n by 1/1/16[1]

Commercial

TCC

- Highmark TCC model currently available through MedNet ACO
- Few providers with Aetna patient panels large enough for TCC

P4V

- Highmark PCMH and Level 1 models available by invitation only
- Aetna P4P and PCMH models available with adequate panel size

15-20% of population by 1/1/16

Medicaid

TCC

- TCC model not yet broadly available from either United or Highmark
- Highmark, Christiana, and Nemours negotiating a TCC model for 2016

P4V

- United and Highmark both have P4V models in development to be rolled out for implementation in 2016

3-5% of population by 1/1/16

1 Medicare adoption of 40-50% pending CMS approval of pending Letters of Intent for Medicare Share Savings Program, and pending outcome of CMS attribution analysis

Your input: Accelerating adoption of value based payment models

Instructions: For this exercise, please use post-it notes to identify who you think the key stakeholders are and how DCHI can best engage them to accelerate adoption of value based payment models

Primary care practices	
Payers	
Aggregators (e.g., ACO, CIN, or groups of providers)	
Employers	
Other	